Bupa Care Homes (CFHCare) Limited

Barton Brook Residential and Nursing Home

Inspection report

201 Trafford Road
Eccles
Salford
M30 0GP

Date of inspection visit: 10 June 2015
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Ratings

Overall rating for this service	Good
Is the service safe?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 12 August 2014. During that inspection we found one breach of Regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the safe management of medicines. After that inspection, the provider wrote to us to tell us what action they had taken to meet legal requirements in relation to the breach of regulation.

As part of this focused inspection we checked to see that improvements had been implemented by the service in order to meet legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Barton Brook Nursing and Residential Home on our website at www.cqc.org.uk.

This inspection was undertaken on 10 June 2015 and was unannounced. We found the provider was still not managing people's medication safely.

Barton Brook Nursing and Residential Home provides nursing, personal care and accommodation for up to 120 older people. The home is owned by BUPA Care Homes. Accommodation is provided in four single storey units with each unit housing up to 30 people. The units go by the names of Monton, Moss, Brindley and Irwell. There is a large car park available at the front of the building.

At our last inspection we found that the registered person had not protected people from the risks associated with the safe administration of medication. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which related to safe administration of medicines.

During this inspection we found that medication was still not being handled safely. These issues related to how medicines were signed for, storage of controlled drugs, records for creams and the accuracy of medication audits completed within the home.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe. We looked at how medicines were administered in two of the four houses (Monton and Irwell). We found medicines were not handled safely in Irwell House so people were not protected against the risk of harm.

Requires improvement

Barton Brook Residential and Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act

2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Barton Brook Nursing and Residential Home on 10 June 2015. This inspection was undertaken to ensure that improvements that were required to meet legal requirements had been implemented by the service following our last inspection on 12 August 2014.

We inspected the service against one of the five questions we ask about services during an inspection, which were not meeting legal requirements, which included; 'Is the service safe.'

The inspection was undertaken by a pharmacist inspector from the Care Quality Commission. Before the inspection, we reviewed all the information we held about the home. We reviewed statutory notifications and safeguarding referrals. We also liaised with external professionals.

During the inspection we spoke with the manager about any improvements that had been made. We also looked at records relating to audits that had been undertaken by the service to monitor the quality of service provision in relation to medication.

Requires improvement

Is the service safe?

Our findings

We looked at medicines handling in two of the four houses and looked in detail at seven people's medicine records on Irwell House. Medicines were stored safely and at the right temperatures. Medicines people needed were available in the home. We watched medicines being given in both houses and saw that this was done safely and in a kind and respectful way.

We saw that people were encouraged to keep and take their medicines themselves if they could do so. Risk assessments were completed to make sure people could look after their medicines with minimum risk to themselves and others.

Extra guidelines for staff (protocols) were written for all the people prescribed medicines only 'when required'. These protocols included administration instructions and how many tablets to give if a variable dose was prescribed.

When we looked at medicine charts we saw that handwritten entries were signed by two nurses to show they had been checked for accuracy. However, some of the writing was untidy and could be misread. The receipt and disposal of medicines was accurately recorded so medicines could be accounted for. One person's medicine had not been signed for the previous day and no explanation was recorded on their medicine chart. The stock level showed that the person had not been given the medicine. As this medicine thins the blood it must be given as prescribed to protect people from harm. The manager took appropriate action when the error was brought to her attention.

Medicines that are controlled drugs (CDs) were stored in the way required by law but CDs in use were not separated from those awaiting disposal. This increased the chance of a mistake. Stock levels of the sample of controlled drugs we checked were correct. One person had recently been given their medicine patch for pain relief a day early. The error had been reported but records of administration in the CD register and on the person's medicine chart were unclear and did not match.

These two administration errors had not been recorded by nurses performing daily audits. This showed some nurses were not following the home's processes for checking that medicines had been administered correctly.

We visited three people in their bedrooms and saw medicated creams that were not

locked away securely. Trained carers applied people's creams. We found that records of application were not kept properly and did not demonstrate that creams had been used as prescribed by the doctor. The name of the cream on one person's record was different to the cream we saw in their room; the nurse told us this was the cream being applied.

The manager carried out medicine audits and had started an improvement plan to correct issues she had found. Since the inspection the home has sent us an action plan of how they intend to rectify the concerns we raised.

These shortfalls demonstrated a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found systems were still not in place to ensure that people living at the home received their medicines safely.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.